Ideas into Action

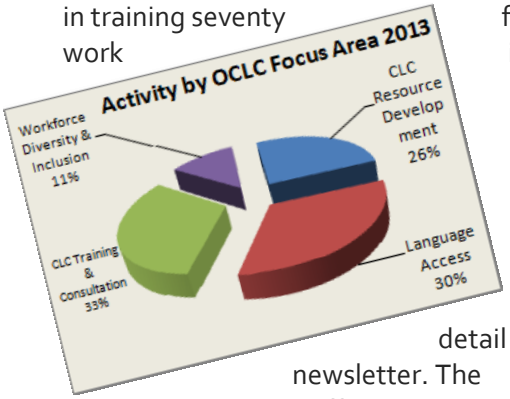
January 2014

Sharing Best Practices and Lessons Learned Related to Cultural Competence and Language Access in Commonwealth's Behavioral Health and Developmental Disability Services (BHDS) system and Beyond

WHAT HAVE WE BEEN UP TO?

The Office of Cultural and Linguistic Competence (OCLC) celebrated its fifth anniversary in 2013! In that 5th year, we continued our cornerstone projects as well as initiated several new initiatives within the four focus areas of the office.

One major initiative that was ongoing in 2013 resulted in training seventy five individuals who work in the BHDS system as qualified bilingual staff interpreters. The Qualified Bilingual Staff Interpreter (QBS) training program is described in detail later in this newsletter. The CLC will continue to offer this training in Richmond, Roanoke, and Hampton Roads in 2014.



This year, we celebrated our 4th annual National Minority Mental Health Awareness Month Media Contest. This year's winners are Eastern State Hospitals Recovery Initiative and Horizon's Behavioral Health's Hudson House. Winners attended a recognition luncheon at Verizon Virginia and a film screening at the State Capitol. The 2014 contest will gear up again in May.

The OCLC supported a number of regional conferences in 2013 including the 3rd Annual Building Bridges Conference which focuses on developmental disability issues in multicultural communities.

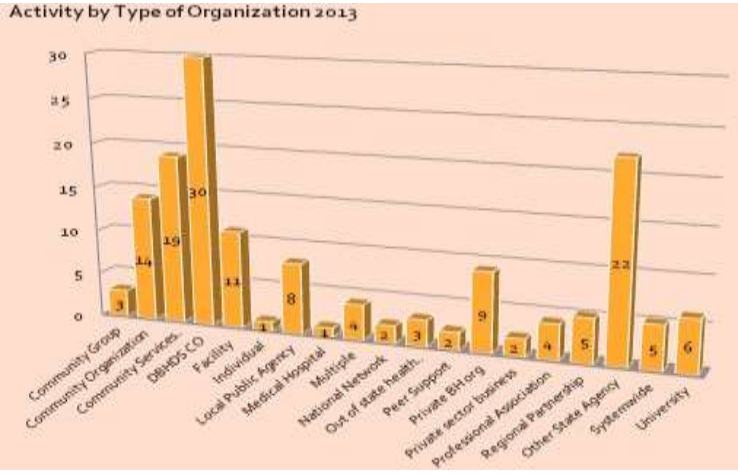
In partnership with the Office of Child and Family Services, we supported a series of regional conferences on cultural competence in systems of care. These conferences were held in four areas of the state and attended by more than 300 participants.

The OCLC continued to develop materials to bolster awareness and strategies on topics related to CLC. This included a series of technical assistance documents on diversity recruiting and retention topics such as the basics of diversity and inclusion and evaluating the workforce for cultural competence.

Assessment and audit documents were also developed to provide guidance on evaluating the competence of foreign language interpreters and language access compliance.

Additionally, we continued to provide training on over thirty CLC topics free of charge to organizations that provide behavioral health and developmental disability services. A list of trainings can be found here.

In June, the Office published a report entitled "An Exploration of Mental Health Needs and Perceptions in Virginia's Refugee Population". This report was created with support from the Virginia Department of Social



Services Office of Newcomer Services as a part of a three year contract to enhance mental health services for refugees in the Commonwealth. We have begun to implement several recommendations in the report as well.

In September, the OCLC teamed up with the Office of Substance Abuse Services to bring trainers from the National Hispanic/Latino ATTC to provide training for substance abuse counselors on Latino cultural elements.

The Virginia Refugee Mental Health Initiative

Eva P. Stitt, Refugee Mental Health Analyst

According to the Virginia Department of Social Services- Office of Newcomer Services (VDSS-ONS), the Commonwealth of Virginia resettles about 2,000 refugees every year. The UN defines refugee as "someone who has been forced to flee his or her country because of persecution, war, or violence." In most cases, a refugee cannot return home or is afraid to do so for fear of his or her life. Some crossed two or more countries by foot and lived in a refugee camp for decades.

Given the harsh conditions that refugees have endured, the toll on physical and mental health is immense. By law, all refugees undergo a health screening during their initial resettlement. And beginning in 2013, a mental health screening component became a part of this process. The Virginia Refugee Mental Health Initiative is a collaborative effort of the DSS-ONS, the Virginia Department of Health-Newcomer Health Program, and the DBHDS-OCLC to support this screening and streamline referrals for mental health services and support. Now in its 3rd year, the initiative is focused on strengthening the existing mental health collaborative in Hampton Roads and Greater Richmond, as well as establishing a similar collaborative in Charlottesville, Fredericksburg, Harrisonburg, Loudoun County, Roanoke, and other parts of the state. Additionally, the initiative is working to support the creation of refugee mental health councils in areas where refugees are resettled designed to enhance communication among stakeholders, build referral resources for refugee mental health, and provide local input on policy development and funding needs for refugee mental health issues. §

The Mid-Atlantic ATTC will be supporting a facilitator training which will allow us to offer this training in Virginia on a regular basis. 2014 trainings are scheduled for the Hampton Roads and Southwest Regions.

Keep up with our activities and products on our webpage or in our CLC Community Page. Join the movement! §

DHHS Office of Minority Health Releases the Enhanced Standards for Culturally and Linguistically Appropriate Services

In 2013, the Office of Minority Health published the final enhanced standards for culturally and linguistically appropriate Services (CLAS). These revisions are designed to provide an even stronger framework to support cultural competence and language access services.

The enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for individuals as well as health and health care organizations to implement culturally and linguistically appropriate services. The enhanced Standards are a comprehensive series of guidelines that inform, guide, and facilitate practices related to culturally and linguistically appropriate health services.

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice (The Blueprint) is an implementation guide to help you advance and sustain culturally and linguistically appropriate services within your organization. The Blueprint dedicates one chapter to each of the 15 Standards, with a review of the Standard's purpose, components, and strategies for implementation. You can view the blueprint and other information about the CLAS Standards here.

DBHDS adopted the CLAS Standards as the framework for addressing disparities. Our CLC programs and initiatives are anchored in these standards. Training and material on the Enhanced Standards will be provided in 2014 and beyond. §

How to Erase Years of Clinical Training in less than Ten Minutes

Professionals of all disciplines spend decades refining their expertise. However, there is one simple mistake that organizations make which can obliterate this expertise within the first minutes of a clinical encounter. This mistake? Failure to use a **tested and trained** interpreter when working with individuals who are limited English proficient or persons who are Deaf, Hard of Hearing, Late Deafend or DeafBlind.

Organizations in our system spend many hours and resources ensuring that staff working for them are licensed or certified in their dicsipline. Organizations also provide ongoing opportunities to ensure that staff are applying the most current practices and approaches in service delivery.

"The irony is clear, even though we value highly trained clinical professionals, we often don't consider how the skill of the interpreter could impact the quality of service provision."

Yet, these same organizations will often allow anyone who says they speak the language communicate for them. The irony is clear, even though we value highly trained clinical professionals, we often don't think about how the skill of the interpreter could impact that high quality service provision. There are countless issues with using an untrained, untested interpreter. Just because someone speaks two languages, it does not mean that they are competent to act as an interpreter.

The DBHDS vision for culturally competent care includes the idea that all individuals, regardless of their English proficiency, have access to high quality programs and services. One of the most significant ways that we can advance this idea is to provide opportunities to bolster the awareness of language services and the capacity for language provision. We do this by encouraging organizations to create a toolbox from which they can pull different language services based on the kind of encounter they will have with an individual.

One "tool" in the toolbox is the **bilingual employee**. It is a common practice to use bilingual employees as ad hoc interpreters from time to time. The problem is that without training and testing, there is no way to ensure that the employee is capable of effective communication.

Research shows that using staff who have not been assessed and trained to interpret impacts the outcomes of any health encounter. On the other hand, staff who know how to facilitate communication between a provider and an individual can greatly enhance the relationship necessary to do our work. Employees who don't have these skills can create a destructive relationship for the provider and the individual being served.

QBS Course March 2013

To address this skills gap, DBHDS offers the **Qualified Bilingual Staff (QBS) Interpreter Training**. The QBS training will ensure that employees who are used in an interpreting encounter have sufficient proficiency in both languages to communicate with the consumer and that they use effective practices to enhance communication for the provider and the consumer.

The goal of the QBS model is to identify, qualify, educate/ enhance, mobilize, and monitor an internal workforce to improve health outcomes and eliminate health care disparities in your organization.

This DBHDS training is for staff working in behavioral health or developmental services who want to build their terminology and gain more exposure to the specific issues when interpreting in these fields. This training is held three times a year and upon request in various locations around Virginia. §

The Problem?

- Unknown language competency (Do they know enough to transmit complex information?)
- No orientation to interpreting in our dynamic settings (How prepared and comfortable are they to interpret in our often unpredictable encounters?)
- No or little knowledge of the complex terminology used in our system (Do they know how to find a similar meaning in another language?)
- Unknown or complicated relationship with patient (Will their relationship with the individual impact the encounter in any significant way?)

A Tool for CLAS Management

The DBHDS Southside CLAS Committee for Central State Hospital, Southside Virginia Training, and Hiram Davis Medical Center in Petersburg recently developed a compliance scoring system for tracking the progress of their CLAS initiatives. The scoring system and qualitative assessment is used to continuously track the results and progress of CLAS activities in meeting each of the 14 National Standards for CLAS in Health Care. The CLAS Committee began to experiment first with a quantitative approach in conjunction with a qualitative approach in 2012. These two approaches guide our facilities through a review process during each quarterly CLAS Committee meeting to review actual performances and identify opportunities and barriers for continuous improvement.

The compliance score form, implementation table, and the report card can help maintain a sharp focus on the overall CLAS performance. It is simple in concept, highly flexible, and easy to use. It only requires some initial efforts, but once it is set up, it can be easily maintained on a sustainable basis. The Southside CLAS Committee is glad to share the above tool and our experience gained in its use with all DBHDS facilities, CSBs, and any outside organizations interested in CLAS implementation. We welcome any suggestions and comments for continuous improvement and enhancement. Our campus CLAS implementation is still in the early developmental stage and has a long way to go. We look forward to any and all participatory and collaborative opportunities for involvement and partnerships with CSBS, DBHDS facilities, and other community organizations.

Contact Person: David Chu, Chair of Southside CLAS Committee. david.chu@dbhds.virginia.gov

Sample Report Card in 2012

(A) Quantitative Measurement (0=Non-Compliance, 1= Minimal Compliance, 2= Partial Compliance,3= Compliance)

	Date	Score	Percentage
	9/29/2011	Eight out of 42	19%
	1/19/2012	Ten out of 42	24%
	4/19/2012	Nineteen out of 42	45%
	7/19/2012	Twenty Five out of 42	60%
	10/18/12	Twenty Nine out of 42	69%

(B) Qualitative Stoplight Check – 3 Zones (Proposed By T. Salisbury)

	Zone Red	Zone Yellow	Zone Green
	"Stop – Need to improve, Needs change and increase"	"Proceed With Caution. On the right track - acceptable results, but should strive for better."	"Good to go – We are proficient in many areas and working toward excellence."
Individual Standards	1?	2,4,6,10,11,12,13	3,5,7,8,9

Compliance Score for Each CLAS Standard			
0 Non compliance	1 Minimal Compliance	2 Partial Compliance	3 Compliance

From 0 ----------→ 3

Successful CLAS initiatives & actions drive continuous improvement over time. The ultimate goal is to reach the maximum possible full compliance score of 42 (3 X 14 CLAS Standards) through persistent and dedicated efforts.

On a continuing basis, CLAS Compliance scores for each standard are adjusted quarterly based on self-assessment of all strategies/activities and the actual performance outcomes. An annual evaluation report will be presented to management.

The following Southside CLAS Implementation table is being used for progress tracking and documentation of activities.

Southside CLAS Implementation (Review Date: _____)

CLAS Standards (Compliance Score)	Strategies/Activities Related to Each Standard	Responsible Person(s)	Time Frame	Implementation Outcome/Status
Std. 1 (Compliance Score)				
	1.1			
	1.2			
	1.X			
through				
Std. 14 (Compliance Score)				
	14.1			
	14.2			
	14.X			

Latinos struggle to find help for mental health issues

According to a recent report by CNN, behavioral health disparities in the Latino community are on the rise. For example, in 2011, 15.9% of Hispanic adults reported suffering from a mental illness the previous year, according to the National Survey on Drug Use and Health. However, among Hispanics with a mental disorder, fewer than 1 in 11 contact a mental health specialist, while fewer than 1 in 5 contact a general health care provider, according to the American Psychiatric Association's Office of Minority and National Affairs. Even fewer Hispanic immigrants seek out these services. Highlights from the report include:

- *Obamacare will give 6 million currently uninsured Latinos access to mental health care*
- *Latinos are less likely than non-Hispanic whites to seek out professional help*
- *Disparity could be linked to lack of Hispanic mental health professionals*
- *Stigma in Hispanic community around mental illness is also a problem, experts say*
- *Latinos struggle to find help for mental health issues*

To view the full report and other in the series, visit www.cnn.com/2013/10/09/health/latino-mental-health-disparities

Commissioner Appoints New Members to Statewide Advisory Committee

The Statewide Cultural & Linguistic Competence Steering Committee (CLCSC) was formed 2008 to advise the Department and provide recommendations to the Commissioner on culturally and linguistically appropriate practices and the elimination of disparities in care. We welcome the new appointees for 2014.

Leigh Freilich, MSW, LSW Family Partnership Meeting Coordinator, City of Charlottesville. Ms. Freilich has served as a facilitator for Charlottesville's Dialogue on Race and led support groups for LGBTQ youth through the Blue Ridge Chapter of the Richmond Organization for Sexual Minority Youth (ROSMY). She is the City's Family Partnership Coordinator, responsible for developing and leading the agency's family engagement efforts.

Richard Gary, Director of Intellectual Disability Services, Danville CSB. Mr. Gary is currently leading an effort in his agency to increase training opportunities and raise community awareness by creating more culturally competent agencies that can better serve individuals of various ethnic groups. Mr. Gary has a Master's in Human Service/Business.

Patricia Hill, Ph.D., LCSW–Prevention/East Center Manager, Henrico CSB. Dr. Hill received a Ph.D. in Social Work from VCU in 2005. Dr. Hill's research interests include the recovery experiences of African American women, cross-cultural social work practice, and resiliency in at-risk populations.

Alima S.M. Palmer- Director, Heritage Multicultural Programs & Services. Ms. Palmer's multicultural behavioral health agency provides trainings, consultation, and services including counseling, crisis intervention, addictions treatment, grief and loss counseling, and case management. She has numerous certifications in DC and Virginia.

Melissa Preston, LCSW- Director, Clinical Social Work. Northern Virginia Mental Health Institute. Ms. Preston has served on NVMHI's Cultural Diversity Workgroup since its inception in 2008. She currently serves as the coordinator of language and ASL services at NVMHI. She is involved with workforce training on ASL, interpreter services, and cultural competence at the facility.

Jennifer Thomasson- Children's ID Support Coordinator, Richmond Behavioral Health Authority. Ms. Thomasson has served as a member of the RBHA Cultural Linguistic Competency Committee since 2009. She has chaired several trainings, as well as organized two successful cultural events for employees. Previous work includes the Virginia Institute of Autism and the Faison School in Richmond. She has a Bachelor's of Science in Psychology from VCU and currently pursuing a Masters in Public Administration.

Julie Truitt – Behavioral Health Consultant, Program, Monitoring, and Oversight (PMO), Virginia Department of Behavioral Health and Developmental Services. Ms. Truitt has an MPA from Central Michigan University and a Bachelor's of Science degree in Criminal Justice and a minor in Human Services Counseling from Old Dominion University. Julie successfully participated and completed The Grace E. Harris Leadership Institute Minority Leadership Institute. §

Meet the New Leadership of the Statewide CLCSC!

Simona Haqq, MSW, MDiv. Clinical Social Worker, Piedmont Geriatric Hospital. Ms. Haqq is the current chair of the hospital's cultural and linguistic competence committee. Ms. Haqq says "What I hope to accomplish as Chair to continue the focus on awareness and eliminating disparities in our multicultural society using the following methods: (1) education and training on CLAS; (2) provision of resources to organizations and communities that encompass different cultures, languages, traditions and spiritual backgrounds to improve quality of care; and (3) support policy development and evaluation of culturally competent services."

Deborah Whitten Williams- Director, Finance and Administration, New River Valley Community Services. Ms. Whitten-Williams is a Certified Diversity Trainer and the Chair of the agency's Cultural Competence Committee. Asked about her vision for the CLCSC, she says "As Vice Chair, I appreciate this opportunity to be part of a team effort to advance the current and future goals of the CLCSC and the Policy Sub-committee. As I move into my second year on the committee, I expect to learn more about what has proven to be successful in the past and use that information along with new strategies to help build future successes."

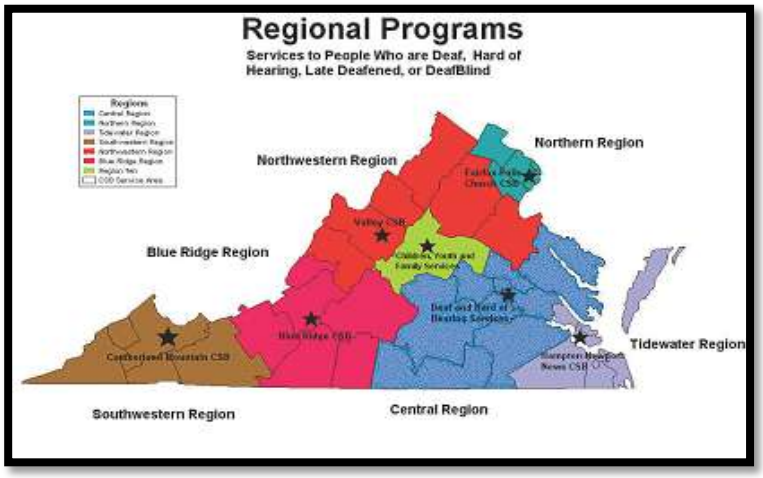
We look forward to this new chapter in the life of the CLCSC.§

Tips for Serving Deaf and Hard of Hearing Consumers, or Persons with a Hearing Loss

With the national prevalence of hearing loss at 8.6%, there is no behavioral health system, rural or urban, inpatient or outpatient, that is immune from serving persons who are deaf, hard of hearing, or deaf-blind. Although the cultural and linguistic needs of persons with a very mild hearing loss may be drastically different from the needs of a person who is deaf and communicates in American Sign Language, there are three basic steps that every clinician can remember in order to ensure that the individual with a hearing loss receives quality care.

First, remember that the individual is coming in for services because they are anxious or depressed, or have another pressing behavioral health issue, not because they are deaf or hard of hearing. Your goal as a clinician is to assess and bridge the possible communication issues and then move on to assessment and treatment. In order to do this, you need to talk about communication needs up front. Instead of asking a person with a hearing loss if they "read lips", ask "what is your preferred method of communication?" Explain that clear communication is important to *you*, the clinician, and that you want to do everything possible to make communication successful. Ask open-ended questions to gauge how your conversation is going. After providing any accommodations at your next meeting, such as a sign language interpreter, check in with the individual at the end of the session to see how communication is working for them. Adjust your plan as necessary.

Second, remember that the communication needs of an individual with a hearing loss in a one-on-one setting may be vastly different than their needs in a group situation. For example, an individual with hearing aids who needs almost no accommodations in a quiet therapist's office may benefit from an induction loop system with well-placed microphones in a group setting. With inpatient treatment, substance abuse treatment, and psychosocial rehabilitation heavily focused on group interventions, it is often challenging to serve persons with a hearing loss in these environments. Clinician's should talk to consumers about their needs in group settings and take steps to make sure accommoda-tions are in place before the service is provided. It may also be necessary to educate all group members on some ground rules for clear communication. An example would be practicing "turn taking" when speaking instead of interrupting the last speaker in order to talk.



Finally, remember that there is assistance available if you need to consult on providing services to persons that are deaf, hard of hearing, and deaf-blind. The Commonwealth of Virginia is covered by Regional Coordinator of Deaf Services positions. Regional Coordinators are employed by a single Community Service Board or Behavioral Health Authority and are tasked with working cooperatively with other CSB/BHAs in the region to assist in providing culturally and linguistically competent care to persons with a hearing loss. Regional Coordinators are fluent in sign language and can provide a myriad of services including direct clinical care, case consultation, and education on deaf culture, education on how consumers can access assistive technology, assistance locating sign language interpreters, and assistance in gaining partial reimbursement for funds spent by CSBs/BHAs on sign language interpreters.

For additional information contact the author of this article, Mike Bush, LPC, who is the Regional Coordinator of Deaf Services in the southwestern region at mbush@cmcsb.com or the State Coordinator of Deaf Services, Kathy Baker, LPC at kbaker@racsb.state.va.us.§

Resources at a Glance

WHAM — En Español! - Health Management Training Available for Latinos with Mental Illnesses and Addictions. The Whole Health Action Management (WHAM) training — an opportunity for people with mental illnesses and addiction to learn how to self-manage their health and wellness. Now available in Spanish. heatherc@thenationalcouncil.org

Understand the legal case for language services. Provides specifics on compliance with Title VI language access laws for federally supported entities. Items of interest are as follows:

- Requirements for vital documents.
- How are EHRs involved?
- What is "meaningful access".
- Who is permitted under the law to provide interpretation and translation services?
- How plaintiffs prove intentional discrimination
- Consequences of non-compliance

View the webinar here. www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-health-disparities-solutions/Events/PastWebinars.html

A growing national registry. You can locate Certified Medical Interpreters on the searchable public CMI registry here: http://www.certifiedmedicalinterpreters.org/registry

In need of resources for working with Refugees? Check out the Healthy Roads Media website. This site contains health education videos and documents in a dozen languages related to both health and behavioral health topics that can be used to increase awareness for refugee individuals with whom you are serving. Healthy Roads develops new material often so be sure to bookmark it! http://www.healthyroadsmedia.org/about_us.htm

Webinar playbacks on relevant topics.
Seeing Generations in the Workforce through a New Lens webinar can be heard at https://linkageincec.webex.com/linkageincec/lsr.php?AT=pb&SP=EC&rID=7833292&rKey=cb9743cbbce31c77

The National Association of State Mental Health Program Directors, Inc. webinar on Enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards in Health & Healthcare can be viewed at http://georgetownuniversity.adobeconnect.com/p6q5dxn7tlm/ §

Magellan Behavioral Health Cultural Competency Resource Kit

As of December 1, 2013, Magellan Behavioral Health of Virginia administers behavioral health services for members enrolled in Virginia's Medicaid and FAMIS programs.

Magellan provides several training and awareness tools to Virginia providers related to cultural competence and language access requirements.

Magellan's Cultural Competence Resource Kit contains a variety of assessment tools, guidelines, standards, and resources designed to assist providers, agencies to enhance cultural and linguistic competence throughout the behavioral health care system.§

A Blueprint for Using Data to Reduce Disparities and Disproportionalties

Disparities and Disproportionalities (D&D) are a well researched reality in human services and behavioral health. They can have a significant impact on individuals, families, and communities. Examples include lack of access to prevention programs, treatment services, or other community resources, and lack of cultural competence. Poverty, which is disproportionate among racial and ethnic groups, is a critical factor to access and quality of care.

But addressing D&D can be complex and requires significant planning and coordination. One tool that can help communities and states develop and implement data-driven strategies is the Blueprint for Using Data to Reduce Disparities/ Disproportionalities in Human Services and Behavioral Health Care. This tool helps communities develop a systematic approach to achieve equity in communities.

Text adapted from the National Network to Eliminate Disparities in Behavioral Health.

Complex Systems, Health Disparities & Population Health: Building Bridges. National Institutes of Health. February 24-25, 2014.Improving population health and eliminating health disparities is a critical task, yet our efforts are stymied by the complexity of the task, involving as it does causes of poor health that range from public policy to the nature of our neighborhoods to how we behave and to our biology.
http://conferences.thehillgroup.com/UMich/complexity-disparities-populationhealth/about.html

Cultural Elements in Treating Hispanic and Latinos. March 4-5, 2014. Western Tidewater Community Services Board. Suffolk. DBHDS has teamed with the National Hispanic and Latino and Mid-Atlantic ATTCs to bring this nationally recognized training to Virginia. This training is by invitation only, however, plans to offer the training to a wider audience are in the future.

23nd Annual Culture Conference- Transforming Life Narratives: Weaving Stories of Healing. Multicultural Family Institute (MFI). April 11 & 12, 2014. Neuman Center, 146 Metlars Lane, Piscataway, NJ. Keynote Guest: Dr. Rockey Robbins, Chocktaw and Cherokee Psychologist. MFI is devoted to post-graduate family therapy training, research, and consultation to community institutions from a Multicultural Systemic perspective.

Cultural and Linguistic Competence in Behavioral Health and Developmental Services Facilitator Training. April 24-25 2014 (tentative). Blacksburg. DBHDS has partnered with Virginia Tech's Language and Culture Institute to develop a curriculum that integrates intercultural studies with cultural and linguistic competence for the BHDS system. Facilitators will be trained to provide up to a four hour course in their organizations and their regions. Participation will be limited to cultural competence coordinators and staff development staff. Participants will be accepted by an application process. For more information, contact Cecily.rodriguez@dbhds.virginia.gov

FREE DBHDS Qualified Bilingual Staff Interpreter (QBS) Training. The 24 hour QBS training is designed for bilingual staff working in the behavioral health and developmental services system who provide "ad-hoc" interpreter services in their organizations. This training will ensure that employees who are used in an interpreting encounter have sufficient proficiency in both languages to communicate with the consumer and that they use effective practices to enhance communication for the provider and the consumer.
Richmond – May 13-15, 2014
Roanoke- August 12-14, 2014
Hampton Roads - Sept 30- Oct 2, 2014
For more information, contact Cecily.rodriguez@dbhds.virginia.gov

Integrating Research, Education, and Services to Reduce Behavioral Health Disparities in Hispanic and Latino Populations. October 8-9, 2014. University of Texas at Austin. National Hispanic/Latino ATTC. For more information view their website at http://www.attcnetwork.org/regcenters/c2.asp?rcid=19&content=CUSTOM2

Is your website culturally competent?

What Does Your Website Say about Your Institution's Commitment to Cultural Competence & Inclusion?

In reviewing your organization's Web page, you might want to assess how well it reflects a commitment to diversity and cultural competence. To that end, start your review by asking the following questions about your institutional Web presence. A rating scale follows these questions.

1. Does your "home page" have a direct link to information, policies, and procedures related to affirmative action, equity, diversity, cultural competence, multicultural initiatives? Is "diversity" one of the choices on the main menu?

2. Does your welcome statement by senior leadership articulate the organization's position on "diversity" and the commitment to promote and support diversity?

3. Can a visitor to your Web page access information/ policies/procedures related to affirmative action, equity, diversity, cultural competence, multicultural initiatives within one click of the organization's main page?

> *"Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations."*
>
> *Cross T., Bazron, B., Dennis, K., & Isaacs, M. (1989)*

4. If your website has a "search" feature, will a search of diversity-related key words (e.g., affirmative action, equal opportunity, diversity, cultural competence, multicultural) produce relevant information?

5. Is the diversity-related information frequently reviewed and updated to ensure that it represents your organization's most current policies, procedures, and initiatives?

> ***Is your website readily accessible to individuals with disabilities?***

6. How is diversity reflected in the images on the page? Are the pictures, graphics, and "motifs" representative of all the elements of the diversity, equation (e.g. racial, ethnic, cultural, gender, disability, etc.)?

7. If job and vendor opportunities are posted, are the organization's statements on affirmative action, equal opportunity, and nondiscrimination prominently displayed and accessible from that section?

8. To what extent does the organization's website display information regarding its diversity-related initiatives and how these impact the community?

9. Are external links to diversity-related resources and diverse communities provided on the organization's website?

10. If your page contains a "news" page or a recurring features page (e.g. company newsletter), do articles/ features often focus on "diversity," or is there an ongoing column dedicated to "diversity" in each issue?

11. Is your website or relevant pages on your website, readily accessible to individuals with limited proficiency in English?

Scoring

0-3	Reflects a **low commitment** to and priority for diversity and cultural competence. You need to take immediate steps by reviewing and revising content so that your website ensures and reflects a growing commitment to diversity and cultural competence.
4-6	Reflects an **emerging commitment** and base-level attention to diversity and cultural competence. Continue to seek opportunities to enhance and expand diversity representation on your Web page.
7-9	Reflects an above **average commitment** to diversity/cultural competence. Continue to strive for excellence.
10-12	You are to be commended for your **high level of commitment** to displaying and integrating.

Article is reprinted with permission. Original source: Access/Equity/Diversity Office, Southeast Community College, Lincoln, NE.

THE YEAR IN PICTURES

2014 National Minority Mental Health Media Contest Winners Recognition

Mental Health First Aid training for refugee health supporters

DBHDS Qualified Bilingual Staff Interpreter Course and other activities in 2013